**FM: Confidential - Referral Form**

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|  **(Please email referrals to: adminnortham@holyoake.org.au)****Referrer’s details: (If self-referred, please skip this section and proceed to Client Details)** |
| **Referring Person** |  | **DOJ No:****(if applicable)** |  |
| **Organisation** |  | **Date of Referral** |  |
| **Contact Details** |  | **Fax No.** |  |
| **E-mail Address** |  |  **After Hours** | **Yes / No** |
| **Client details** |
| **Name** |  | **Aboriginal / TSI****(Please Circle)** |  **Yes / No** |
| **Date of Birth** |  | **If Aboriginal would you prefer an Aboriginal Counsellor****(Please Circle)** | **Yes**  |
| **Country of Birth** |  | **Male** |  | **Female** |  | **Other** |  |
| **Residential** **Address** |  |
| **Postal Address** |  |
| **E-mail Address** |  |
| **Mobile No:** |  | **Home / Work No.** |  |
| **Has current Driver’s Licence?** |  | **Own transport?** |  |
| **Client Type** **(Circle)** | **Own Drug****Use** | **Other’s Drug****Use** | **Both Own****& Others** | **Non AOD****Issue** |
|  |
|  **Preferred engagement** **(Pls circle multiple modalities if applicable)** |  **Face-to-face Video Telephone**  **Counselling Counselling Counselling** |

**Current Substance Use**

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| --- | --- | --- | --- | --- | --- |
| **SUBSTANCE** | **Yes****(Tick)** | **Frequency****Of Use** | **Quantity****(Each Use)** | **Duration****Of Use (Months)** | **Additional****Information** |
| **Alcohol** |  |  |  |  |  |
| **Cannabis** |  |  |  |  |  |
| **Amphetamines** |  |  |  |  |  |
| **Heroin** |  |  |  |  |  |
| **SUBSTANCE** | **Yes****(Tick)** | **Frequency****Of Use** | **Quantity****(Each Use)** | **Duration****Of Use (Months)** | **Additional****Information** |
| **Other Opiates** |  |  |  |  |  |
| **Hallucinogens** |  |  |  |  |  |
| **Party Drugs (XTC, GHB)** |  |  |  |  |  |
| **Cocaine** |  |  |  |  |  |
| **Prescription Medication** |  |  |  |  |  |

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| **Mental Health** | **Yes** | **No** | **Unsure** | **Comments** |
| **Suicidal Thoughts** |  |  |  |  |
| **Suicidal Behaviour** |  |  |  |  |
| **Self-Harm Behaviour** |  |  |  |  |
| **Aggressive Behaviour** |  |  |  |  |
| **Anxiety** |  |  |  |  |
| **Depression** |  |  |  |  |
| **Mood Disturbance** |  |  |  |  |
| **Delusions** |  |  |  |  |
| **Paranoia** |  |  |  |  |
| **Hallucinations** |  |  |  |  |
| **Other** |  |  |  |  |
| **Known Mental Health Treatment/History** |  |  |  |  |

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| --- | --- | --- | --- | --- |
| **Physical Health** | **Yes** | **No** | **Unsure** | **Comments** |
| **Current Issues** |  |  |  |  |
| **History** |  |  |  |  |
| **Medications** |  |  |  |  |
| **Pregnancy / Breastfeeding** |  |  |  |  |
| **Seizure History** |  |  |  |  |

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| **Accommodation** | **Yes** | **No** | **Unsure** | **Comments** |
| **Stable/Safe Housing** |  |  |  |  |
| **Relationships** | **Yes** | **No** | **Unsure** | **Comments** |
| **Domestic Violence** |  |  |  |  |
| **Children / Dependants** |  |  |  |  |
| **Parenting Concerns** |  |  |  |  |
| **DCP Involvement** |  |  |  |  |

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| --- | --- | --- | --- | --- |
| **Legal Issues** | **Yes** | **No** | **Unsure** | **Comments** |
| **Current Police Charges** |  |  |  |  |
| **Prior Convictions** |  |  |  |  |
| **Court Involvement** |  |  |  |  |
| **DOCS Involvement** |  |  |  |  |
| **Family / Other** |  |  |  |  |

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| **Financial**  | **Yes** | **No** | **Unsure** | **Comments** |
| **Employed** |  |  |  |  |
| **Centrelink** |  |  |  |  |
| **Financial Hardship** |  |  |  |  |
| **Unmanageable Debt** |  |  |  |  |

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| --- | --- | --- | --- | --- |
| **Social Support** | **Yes** | **No** | **Unsure** | **Comments** |
| **Family**  |  |  |  |  |
| **Pro-Social Friends** |  |  |  |  |

**Reasons for Referral**

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**Other Agencies Involved**

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**Release of Information Clause**

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| --- | --- | --- | --- | --- | --- |
| **Client to Contact WCADS For Appt?** | **Yes** | **No** | **Referrer to Contact WCADS For Appt?** | **Yes** | **No** |
| **Parents to Be Involved****(If Applicable)** | **Yes** | **No** | **Authorisation for WCADS To Contact Client** | **Yes** | **No** |

**If applicable, I give consent for WCADS to receive a copy of RAMP / Discharge Plan / TRIAGE.**

**Yes / No**

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| --- | --- | --- | --- |
| **Client Signature:** |  | **Date:** |  |
|  |  |  |  |
| **Parent Signature:****(if client under 18yo)** |  | **Date:** |  |

*HOLYOAKE Wheatbelt Community Alcohol and Drug Service*

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PO Box 375, Northam WA 6401

Telephone: (08) 9621 1055